

Medicopolitical digest

Medical academic staffs conference

Academics call for a fairer research assessment

Medical academic staff have called for the research assessment exercise (RAE) to be fairer and more representative. At their annual conference last week the representatives declared that the use of impact factors was a totally inappropriate method of assessing medical research and called on the BMA to examine fairer alternative methods.

The RAE takes place every four years, and its aim is to measure the quality of research across all higher education and determine central funding for academic units in Britain. The assessment is based on peer review, including examination of published research and information about numbers of research students and research income during the assessment period.

The Medical Academic Staff Committee has criticised the exercise since its inception because of emphasis on research at the expense of teaching and service work. The 1997 Dearing report into higher education recommended a review of the exercise and the Higher Education Funding Council for England has set up a task force.

Unscientific and unjust

Last week's meeting wholeheartedly endorsed Professor Gareth Williams's forthright account of why he believes the RAE is unscientific and unjust. Professor Williams, professor of medicine at the University of Liverpool, published his views in April (4 April, pp 1079-82).

He told the conference that the RAE had acquired such a momentum that it was almost impossible to stop. He said that it was wasteful of time and money; the data were misleading and unscientific; and the conclusions were biased and unjust. It ignored people who were not funded by the higher education funding councils and ignored total published output. There was potential for abuse—for example, a researcher's publications at one unit are transferred with the researcher to a new post and staff funded by councils were used to submit publications from ineligible researchers. Professor Williams said that the system was totally unaccountable. The assessment was subjective; there was no audit or peer review; and inconsistency between panels.



CHARLES WILLIGAN

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It can be made to work

To be made to work he said that the RAE had to be based on accurate, complete, and valid measures of research success; be fair, transparent, and fully accountable; informative; and quick, efficient, and cheap to operate. He suggested that a group's submission should include its total published output since the previous assessment. Its assessment score would be the sum of its publication scores—that is, the product of journal category and attribution factor for each publication. Journals' impact factors should not be used to measure quality.

The chairman of the MASC, Dr Colin Smith, said, "If it is unmodified the RAE will destroy medical schools. The latest changes proposed by the funding council just trims the edges. There needs to be dramatic changes." Dr Smith reported the committee's concerns to the House of Commons science and technology committee when he gave evidence earlier this year.

Pay parity achieved in nearly all schools

Dr Smith told the conference that although the government now placed a condition on its grant to the funding councils that universities should meet pay increases awarded to NHS doctors for their own medical staff Sheffield and Bristol had delayed paying the 1998 award until June. "This is unacceptable," Dr Smith said, "there should be no manipulation of pay awards."

For non-clinical academic staff the position was very different. "They have fallen so far behind clinical academic staff that it is no wonder that recruitment is almost zero," Dr Smith said. They were at a disadvantage over terms of service, such as removal expenses and maternity leave and lost two years' pensionable service when transferring from the universities' superannuation scheme to the NHS. Dr Smith said that the MASC would be giving evidence to the Independent Review Committee, which has been set up to look at all aspects of university employment terms and conditions of service. He hoped that the committee would look particularly at recruitment. The conference resolved that the review committee should establish a separate subcommittee for academic medicine.

Teacher training for all is impractical

The Dearing report on higher education recommended the establishment of an institute for learning and teaching in higher education. The conference welcomed the emphasis on teaching the teachers but resolved that the recommendations were impractical. It insisted that any proposals should recognise the developments that were already taking place in medical schools, particularly since the publication of the General Medical Council's book, *Tomorrow's Doctors*. Dr Smith said that he could not endorse the requirement that all teachers in medicine should study for a teaching certificate. However, he hoped that in the future promotion by teaching portfolio would be as important as a research portfolio.

Role of Quality Assurance Agency is confusing

The Dearing report recommended that the remit of the Quality Assurance Agency should be amended to include quality assurance and public information; standards verification; the maintenance of the qualifications framework; and a requirement that the arrangements for these are included in a code of practice which each institution should adopt by 2000-2001 as a condition of public funding. Dr Charlotte Mackenzie,

who is responsible for the medical subject review, told the conference that the agency would be collaborating with professional and statutory bodies, such as the GMC. She said that the agency had persuaded the universities to pay more attention to teaching than to research. The universities would be able to bid for money to improve teaching after the assessment. Dr Mackenzie said that guidelines would be produced shortly.

Dr Colin Smith, who has been appointed a quality assessor in Southampton, thought that there would be a duplication of responsibilities with the GMC. He said that there was still a lack of

clarity about the roles of the agency and GMC, and there was potential for disagreement and confusion between the two organisations.

Tuition fees should be monitored

The meeting deplored the introduction of tuition fees for students and called on the government to monitor and publish the effects. Dr Peter Johnston, lecturer in pathology in the University of Aberdeen, said that tuition fees hit medical students particularly

hard; their average debt was now over £4000. More of them would have to find ways to raise money and this would cut down the time they had to study. He feared that there would be more student drop outs.

Miss Zoe Silvestone from the BMA's medical students committee called for the fees to be retained in higher education as an addition to current spending in real terms and allocated by a body with adequate student representation. The government had said that the money would go to the universities but this had to be made transparent.

Senior staffs conference

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Consultants should be represented on PCGs

Consultants want to be represented on primary care groups (PCGs) and primary care trusts to ensure that those commissioning primary and secondary care have medical advice from the secondary sector.

Dr Jaswinder Bamrah told the senior staffs conference last week that he was worried that PCGs would divide the profession as fundholders had done. "We want to work in cooperation with our GP colleagues and contribute to the reshaping of primary care policies." If consultants were not in at the beginning they would have no impact.

Dr Tiz North, a consultant radiologist in Carshalton, urged consultants to act now while the groups were being set up and not wait for the government to take action. She said that all consultants should share the burden and not leave it to clinical and medical directors.

Dr Rosemary Eames, a consultant histopathologist in King's Lynn, agreed. She did not think that the new system would see the end of the internal market. PCGs would have most of the money and would be given a steer by health authorities. "If we are not represented how will secondary care be commissioned?"

set up. Some services were being provided by former clinical assistants, who were previously supervised in hospital, and some doctors had taken distant learning courses. Although dermatologists were worried about their waiting lists, this was a retrograde step. Patient groups were concerned that a consultant based service was not being provided. "What happens in dermatology today will affect your specialty tomorrow," Dr Marsden warned.

A dermatologist in Taunton, Dr Conrad Guerrier, said that if GPs were to provide a service they should work under the supervision of a hospital consultant. He thought that they should have at least the certificate of completion of specialist training.

Supporting the motion the CCSC chairman, Mr James Johnson, said that patients were not getting a decent deal. Where a service was provided in the community the terms of the 1996 circular, *A Framework for the Provision of Secondary Care within General Practice* should be adhered to.

There should be a moratorium on PFI

Consultants have called for a moratorium on new private finance initiatives (PFI) in the

hospital sector until the advantages have been shown.

Dr Robin Davies, a consultant paediatrician in Gwynedd, said that it would be mad to advise such a move when under the present rules PFI was usually the only source of finance for desirable initiatives.

But he was overruled. Dr Allyson Pollock, a public health consultant in London, told the meeting that there was a great deal of secrecy about the deal. The escalation in costs was about 100%. The scheme in Walsgrave had escalated from £30m to £180m and the Edinburgh Royal Infirmary from £160m to £250m. The costs were not coming out of capital but from revenue, from the clinical services budget. There would be a 10% capital charge made on every hospital to pay for PFI. There would be cuts in community and acute services. She had been told that for every £200m of PFI investment 1000 clinical jobs would be lost. "There must be a moratorium; otherwise you will be mortgaging everyone's future and you will have no NHS."

Conference throws out proposal for differential pay

There was an overwhelming defeat for a proposal that consultants' pay should reflect differing levels of workload and responsibilities.

There was already variation in the form of extra notional half days and discretionary points, argued Dr Gillian Markham on behalf of the Mersey Regional Consultants and Specialists Committee. "It is time to formalise the concept and move towards more work sensitive payments." She reminded the meeting that this year the review body had awarded extra money to GPs on condition that it was targeted at those who worked hardest. She said that the proposal need not be divisive. Physicians in her hospital had negotiated extra notional half days for extra commitments; two had decided that they did not want to take on extra work and did not get the extra money.

Specialist services should be delivered by specialists

GPs who carry out work usually done by consultants should have the appropriate training and work within agreed protocols.

Proposing this successful motion, the chairman of the Central Consultants and Specialists Committee's dermatology and venereology subcommittee, Dr Allan Marsden, said that there were about 30 GPs providing secondary dermatological services. These were being paid for by purchasers but in some places, he said, the necessary panels for assessing the GPs had not been



Mr James Johnson gave his last address as chairman of the BMA's consultants' committee

PHIL WEEBON/BMA NEWS REVIEW

She was supported by Dr Philomena Cantrell, a consultant radiologist in Warrington, who said that demands for realistic increases had fallen on stoney ground. Those consultants who had a greater workload and who were expected to be on call should be paid more. And Dr Paul Miller, a consultant psychiatrist in Sunderland, said that it was time to change the policy. "If this is the only way to do better we must do it," he said.

But other speakers said that that such a move would be divisive. It might lead to job evaluation and an NHS pay spine. Dr Elizabeth Stockdale, a consultant radiologist in Aberdeen, said that it would lead to a several tier consultant service. The last government, she said, had tried to set GPs against consultants, "we do not want to set consultants against consultants." And Dr Henry Fell, a microbiologist in Bury St Edmunds, said that he had not come into the profession to leapfrog over his colleagues. The chairman of the negotiating subcommittee, Dr Peter Hawker, advised, "If you believe in equity among consultants you should reject this motion."

Clinical need not waiting lists should determine treatment

There was strong condemnation of the government's obsession with waiting lists and criticism of the fact that surgeons had their operating lists cancelled because of lack of money while in other hospitals non-urgent cases were being treated to reduce list sizes. Dr David Cairns, a consultant surgeon in High Wycombe, said that he had some patients waiting 15 months for treatment but lists had to be cancelled because the hospital was ahead of its contract.

Mr Kanwar Panesar, a consultant surgeon in Londonderry, called the waiting list initiatives a waste of time. The government had fallen into a trap.

The government has created a rod for its own back, Mr Johnson declared. "Numbers on waiting lists are bunk." What matters was how long patients were on waiting lists.

Non-consultants will get legal help

The CCSC chairman gave an assurance to non-consultant career grade doctors that if the committee was permitted to pursue a judicial review to challenge the surgical royal colleges' insistence on an exit examination for entry to the specialist register under the transitional arrangements it would do so.

The meeting passed a motion deploring the difficulties faced by non-consultant career grade doctors in gaining admission to the specialist register; but Mr James Johnson explained that the CCSC had been successful in getting the law changed so that a doctor's experience was taken into account under the transitional arrangements for



Representatives at the senior staffs conference

entry to the register and it had also managed to get the deadline extended. But counsel's opinion had been taken on the question of the unacceptability of Irish qualifications held by non-consultant career grade doctors. It would, he explained, be impossible to treat the Republic of Ireland differently from other European Union countries. The Specialist Training Authority was a statutory organisation and the wording of the Specialist Medical Order was constrained by the European medical directive.

The conference called on the government to stop further use of non-standard grades; regretted the slow implementation of the new staff grade contract; and deplored the continuing failure of many trusts to award discretionary points to associate specialists.

The NHS must have more funds

The meeting agreed that if the government's wish to improve the quality of the service provided by the NHS was to be met more funds were needed.

The public wanted a Rolls Royce service, Dr Robin Arnold, a psychiatrist in Bristol, said; demand and expectation of quality were both increasing.

When PCGs held the budgets there was a danger that both primary and secondary care services would be destabilised, Dr Allyson Pollock, a consultant in public health medicine in London, told the meeting. The edict from the Department of Health was that health authorities and trusts must get rid of their deficits. PCGs would not be prepared to take on services and planning if the deficits were still in place. So capacity was being removed and Dr Pollock forecast a third of acute beds disappearing within two or three years. So the promised increase of 1.5% was dismal and the meeting should support demands for a significant increase in funding.

Mr James Johnson said that the present health secretary in England had not done badly in getting additional funding for the NHS; he hoped that there would be more. When the BMA had demanded an additional £6bn some years ago it had been derided; it no longer seemed such a ludicrous amount.

The conference ...

- Called for education and training of doctors to be fully funded
- Was disappointed that education figured so little in the NHS white papers
- Believed that a doctor's obligation "to act quickly to protect patients from risk" should be professional rather than contractual
- Resolved that disciplinary and appeals procedures should be on agreed national terms and conditions and not subject to individual trust policies
- Called for the annual medical school intake to be increased by 1000
- Condemned the staging of the review body's 1998 award
- Resolved that a GP's decision as to which consultant to refer a patient should not be constrained by private health insurers
- Urged the BMA's medical ethics committee to look at the legal issues surrounding the rights of a fetus in late pregnancy.

GP non-principals have special education needs

The 4000 doctors who work as non-principals in general practice in England are an educationally disadvantaged group, according to a survey by the Standing Committee on Postgraduate Medical and Dental Education (SCOPME).

In *The educational needs of general practitioner non-principals* SCOPME recommends, for example, that the mechanism for setting up a register of GP non-principals should be examined; induction to practices should be provided; a written statement about employment terms should be given to eligible GPs specifying time available for education during contracted hours; professional career counselling should be provided; non-principals should be included in mentoring schemes and helped to draw up personal development plans; non-principals should be routinely notified of local educational activities and should receive personal copies of important publications; and written information should be provided about their eligibility for educational funding.

The Educational Needs of General Practitioner Non-principals is available from SCOPME, 1 Park Square West, London NW1 4LJ. A summary is on the SCOPME website at www.scopme.org.uk.

BMA's ARM agenda

The agenda for the BMA's annual representative meeting in Cardiff from 6 to 9 July is enclosed with this issue. Members in the UK who do not receive a copy should contact the BMA secretariat: 0171 383 6148.

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